Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
COMBINED CHIROPRACTIC SERVICES & REHABILITATION, INC.
PO BOX 700311
SAN ANTONIO TX 78270

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 45

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Date Received
JULY 20, 2011

MFDR Tracking Number
M4-11-4225-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the Table of Disputed Services: "medical necessity established"

Amount in Dispute: $225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office performed an in-depth review of the dispute packet submitted by the Combined Chiropractic Services and Rehab and will maintain its denial for ANSI code 50-Services not deemed medically necessary and 210 – Based on Extent of Injury. The injured worker attended a Required Medical Examination as approved by the Division in which Dr. Douglas Stauch performed on 7/29/2009. He was asked to address specific issues relative to the injury of May 2005. Dr. Stauch performed an in-depth examination and was asked to determine appropriateness of medical treatment which in his opinion treatment for the first 2 months after May 15, 2005 was appropriate. All treatment appears related to her previous surgery, which has a Pseudoarthrosis and then possibly to development of unrelated stenosis later at L3-4. When asked is further treatment, prescription medications, or diagnostic testing reasonable and necessary and related to the on the job injury he answers with 'No further treatment of any kind, prescription medications or diagnostic testing is necessary for her injury of May 15, 2005, which could be described as a lumber strain or entirely due to the pseudoarthrosis from her previous surgery. Her current medications may be necessary for her current medical condition, but their use would not be related to the work injury;. The Office notes that as of the date of this response there has not been a Benefit Review Conference requested to address Dr. Stauch's findings that the injured workers current complaints are not related to the work incident that occurred in May 2005. Therefore the Office will maintain its denials for the services that were rendered by this provider on 10/22/2010."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2010	CPT Code 99204	$225.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
5. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. 28 Texas Administrative Code §133.250 sets out the procedures for health care providers to request reconsideration.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - T13 – Medical necessity denial. You may submit a request for appeal/reconsideration no later than 11 months from the date of service.
   - 219 – Based on extent of injury (Note: To be used for Workers' Compensation only).
   - Diagnosis unrelated to compensable work injury. Per IME on file, current treatments are realted to prior, non-work related injury.
   - 29 – The time limit for filing has expired. The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC Codes(s) and/or total bill charge amount, thus making it a new bill and subject to the 95 day timely filing rule.

Findings

1. This dispute is related to an office visit initially denied using denial code 50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer"; T13 – "Medical necessity denial. You may submit a request for appeal/reconsideration no later than 11 months from the date of service" and 219 – "Based on extent of injury." The requestor filed a request for reconsideration and the respondent denied the services using denial code 29 – "The time limit for filing has expired. The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC Code(s) and/or total bill charge amount, thus making it a new bill and submit to the 95 day timely filing rule." According to the respondents position summary they are maintaining the medical necessity and extent of injury denial. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to

28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

2. In regards to the respondent denying the services using denial code 29 - "The time limit for filing has expired. The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC Code(s) and/or total bill charge amount, thus making it a new bill and submit to the 95 day timely filing rule" the carrier states on the EOB that "The Provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC Codes(s) and/or total bill charge amount, thus making it a new bill and subject to the 95 day timely filing rule. Review of the two bills filed by the requestor both dated May 18, 2011 show diagnosis codes billed were: 1. 724.4 2. 722.83 and 3. 724.2; however, the first explanation of benefits dated January 5, 2011 shows only 722.83 – POSTLAMINECT SYND-LUMBAR; the second explanation of benefits dated June 13, 2011 shows 724.4, 722.83 and 724.2 in that order. According to the preamble of 28 Texas Administrative Code §133.250(d)(1) a request for reconsideration may include changes in the number of units or modifiers from that in the original bill. The requestor changed the diagnosis codes making the request for reconsideration a new bill. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services and has forfeited the right to reimbursement due to untimely submission. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 19, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.